ADDICTIONS RECOVERY

When Knowing the FACTS Can Help

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The Addiction Technology Transfer Center Network

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Why do we say addiction is an illness requiring a continuum of care?

CONTINUUM OF CARE includes all levels of care and should be defined as:

- **comprehensive and integrated (prevention, treatment and recovery support).**
- **able to demonstrate improved quality, capacity and effectiveness of Alcohol and Other Drugs (AOD) prevention, treatment and recovery support through better use of data and the application of continuous quality improvement practices.**

Ohio Department of Alcohol and Drug Addiction Services (2005) Redesigning Ohio's Continuum of Care and Service Taxonomy Phase I Report. Retrieved August 21, 2007 from http://www.google.com/search?hl=en&q=Ohio+Department+of+Alcohol+and+Drug+Addiction++Services+%2B+Redesigning+Ohio%E2%80%99s+Continuum+of+Care+and+Service+Taxonomy+Phase+I+Report+&btnG=Search

Individuals with substance use disorders require continuing care because of the nature and course of the illness. Drug addiction is a complex illness. It is characterized by compulsive—at times uncontrollable—drug craving, seeking, and use that persist even in the face of extremely negative consequences. For many people, drug addiction becomes chronic, with relapses possible even after long periods of abstinence (NIDA, 1999). Addiction can cause permanent changes in brain structure and chemistry. This is demonstrated through three decades of scientific research and clinical practice that have yielded a variety of effective approaches to drug addiction treatment (Harvard, 2007; NIDA, 1999; Dennis et al, in press). It is not just illicit drug use but also misuse of prescribed medications. Illicit substance abuse is a major national public health problem that creates impaired health, harmful behaviors, and major economic and social burdens... but there are effective medical and public health approaches to the problem." (Physician Leadership on National Drug Policy, 2002).

NIDA Director, Dr. Nora Volkow states, "Drug addiction is a brain disease. Although initial drug use might be voluntary, once addiction develops, this control is markedly disrupted." (Volkow, 2007). As such, addiction is an illness requiring a continuum of care, like diabetes, asthma or hypertension. Just like these diseases, a single course of treatment is unlikely to result in a complete and permanent "cure." Similar to hypertensive patients, individuals with addiction may require multiple courses of treatment to stabilize their condition. The difference between addiction and other chronic conditions is that for addiction there is (1) the issue of level of care—not everyone needs extensive treatment; and (2) people need stepped-down care after formal treatment—a critical part of the continuum of care that is currently not provided in the addiction field. Relapse rates for treatment of alcohol, opioids and cocaine are less than those for hypertension and asthma, and equivalent to those of diabetes—all chronic conditions. In fact compliance rates for treatment of alcohol, opioids and cocaine are greater than compliance rates for hypertension and asthma. (O'Brien & McLellan, 1996).

Substance dependence is indeed a chronic illness and the system of care, including treatment and funding mechanisms, must acknowledge this fact by providing continuing care using evidence-based methods and practices to effectively manage addiction and foster sustained symptom remission. Skeptics ignore the fact that when the system uses a model of care that is not matched to the clinical course of the disorder being treated (i.e., using an acute model to treat a chronic condition), it can lead to the wrong "dose" of care and outcomes that can hardly be better than if a system treated all cancer with one dose of radiation. (Flaherty, 2006).

Conceptualizing addiction as a chronic illness actually expands the understanding of how to approach other chronic illnesses given its strong self-care or peer-supported programs that are only beginning to be applied in the management of other chronic illnesses (Flaherty, 2006). The shift to a continuum of care for substance dependence can help change attitudes of people who may still want to believe that substance dependence is self-induced by the individual's will or moral failing and, therefore, should be the individual's problem alone to solve (Flaherty, 2006).

EFFECTIVENESS

▶ The studies of Dennis, Scott and colleagues (2003) and McKay's (2005) recent review of research on extended interventions confirm the potential usefulness of post-treatment monitoring (via recovery check-ups and active linkage to recovery supports). There is also evidence that such effects can be achieved using low-cost delivery formats (e.g., telephone-based check-ups and support).

McKay, J. R. (2005). Is there a case for extended interventions for alcohol and drug use disorders? *Addiction, 100*(11), 1594-1610.

▶ Individuals progress through drug addiction treatment at various speeds, so there is no predetermined length of treatment. However, research has shown unequivocally that good outcomes are contingent on adequate lengths of treatment. Generally, for residential or outpatient treatment, participation for less than 90 days is of limited or no effectiveness, and treatment lasting significantly longer often are indicated. For methadone maintenance, 12 months of treatment is the minimum, and some opiate-addicted individuals will continue to benefit from methadone maintenance treatment over a period of years.

National Institute on Drug Addiction, U.S. Department of Health and Human Services, National Institutes of Health. (1999). *Principles of Drug Addiction.*

NOTE: IRETA's study to date indicates that for a diagnosis of substance use dependence, the continuum of care should best include treatment and recovery supports of varying lengths and combinations.

▶ For a given level of treatment history and current need, those who get more treatment or treatment sooner are indeed likely to do better.

Dennis, M.L., Scott, C.K., Funk, R., & Foss, M.A. (2005). The Duration and Correlates of Addiction and Treatment Careers. *Journal of Substance Abuse Treatment, 28*(S1), S51-S62.

▶ The majority (69%) of patients who had medical conditions related to their addiction, and who received both medical care and addictions treatment were abstinent six months after leaving treatment.

Weisner, C., Mertens, J., Parthasarathy, S., Moore, C., & Lu, Y. (2001). Integrating Primary Medical Care with Addiction Treatment, A Randomized Controlled Trial. *Journal of the American Medical Association, 286*(14), 1715-1723.

▶ In DATOS, the effects were sometimes clear cut. In the year after leaving residential rehabilitation or non-residential counseling, 80-90% of long-stay (at least three months) clients who had been using heroin or cocaine weekly before treatment were no longer doing so. For clients who left earlier, the figure was 50-60%

Franey, C. Ashton, M. (2002). The Grand Design Lessons from DATOS. *Drug and Alcohol Findings*, 7, 5.

▶ Treatment follow-up studies report an average full remission rate of one-third and significant reductions in AOD (alcohol and other drug) use/AOD-related problems for most clients.

Miller, W. R., Walters, S. T., & Bennett, M. E. (2001). How effective is alcoholism treatment in the United States? *Journal of Studies on Alcohol, 62*(2), 211-220.

▶ Offering lower intensity, continuing treatment to individuals who have completed a more intensive initial phase of rehabilitation would seem to be a clinically effective, as well as cost-effective, approach to the treatment of any chronic disorder such as substance abuse.

McKay, J.R. (2001). Effectiveness of Continuing Care Interventions for Substance Abusers: Implications for the Study of Long-Term Treatment Effects. *Evaluation Review, 25*(2), 211-232.

▶ The conclusion that addictions treatment is effective is demonstrated in over 600 published scientific papers.

Marwick, C. (1998). Physician Leadership on National Drug Policy Finds Addiction Treatment Works. *Journal of the American Medical Association, 279*(15), 1149-1150.

SOURCES:

Dennis, M.L., Foss, M.A., & Scott, C.K. (in press) An 8-Year Perspective on the Relationship between the Duration of Abstinence and Other Aspects of Recovery. Evaluation Review.

Flaherty, M. (2006). *Special Report-A Unified Vision for the Prevention and Management of Substance Use Disorders: Building, Resiliency, Wellness and Recovery-A Shift from an Acute Care to a Sustained Care Recovery Management Model.*

Harvard Mental Health Letter, *Addiction and The Problem of Relapse*, January, 2007

O'Brien, C.P., & McLellan, A.T. (1996). Myths about the Treatment of Addiction. *The Lancet*, 347, 237-240.

O'Brien, C.P., & McLellan, A.T. (1996). Myths about the Treatment of Addiction. *The Lancet,* 347, 237-240.

National Institute for Drug Abuse. (1999). Principles of Drug Addiction Treatment: A Research Based Guide.

PLNDP (2002) Adolescent Substance Abuse: A Public Health Priority, Physician Leadership on National Drug Policy.

Volkow, N. (2007). Recovery in Action Rising. Winter 2007. Retrieved March 12, 2007 from www.facesandvoicesofrecovery.org

What are the benefits of linking formal treatment to recovery support services?

Recovery is not simply sobriety — While sobriety is considered necessary for recovery, it (alone) is not considered recovery.

The Betty Ford Institute Consensus Panel. (In Press) What is Recovery? A Working Definition From the Betty Ford Institute, July 2007 in press, *Journal of Substance Abuse Treatment.*

Recognizing the recovery community as a valuable adjunct to addiction treatment is not a novel concept. In fact, in the 60s and 70s, modern addiction treatment came of age as a community-based phenomenon. Fortunately, even as treatment for physical ailments has become more advanced, treatment for addiction has never fully strayed from its roots—it has never lost sight of the unique value and perspective of those who have "been there."

However, addiction has proven to be a formidable and recalcitrant foe. As researchers, the treating community and addicts alike have come to understand or at least appreciate the complex, multi-faceted face of addiction, they have increasingly accepted the fact that treating it with anything less than everything is doomed to failure. Yet many studies show that more is not necessarily better. Treatments that target specific problems (addiction and co-occurring) at the patient level and help patients to engage long-term in pro-recovery behaviors such as AA attendance do better than other interventions.

So, what are the benefits of linking formal treatment to recovery support services? The short answer is simply that we all will have a fighting chance if we work together.

And what better partnership than treatment professionals who, ideally, stay abreast of the very latest in treatment techniques, who understand the interplay between psychology, biology and learning theory and persons in recovery who, too often, have themselves been knocked to their knees only to get back up, dust themselves off and try again, one day or minute at a time.

In light of the serious work force issues where the funding is often scarce, the treatment community can, should and must rely on the supportive recovery advocates in the community to ensure the best opportunity for recovery is afforded to all who need it.

This alliance is all the more vital considering empirical finding showing that the majority of those who achieve stable recovery do so only after several episodes of treatment over multiple years (Anglin, Hser, & Grella, 1997; Dennis et at., 2005; Grella & Joshi, 1999; Hser, Anglin, Grella, Longshore, & Prendergast, 1997; Hser, Grella, Chou, & Anglin, 1998). In sum, treatment and recovery supports are the only answer.

The benefits of linking formal treatment to recovery support services not only bring us back to our successful roots, but they also bring us to share our resources while minimizing the duration and multiple costs of addiction careers by promoting recovery initiation, resiliency, wellness and long-term recovery.

SOURCES:

White, W, Kurtz, E., (2006). *Recovery: Linking addiction treatment & communities of recovery: A primer for addiction counselors and recovery coaches.* IRETA publication. Retrieved March 20, 2007 from www.ireta.org

Given the chronic nature of substance dependence disorders (McLellan, Lewis, & O'Brien, 2000; White, 2005) and the scarcity of funds for treatment, neither single- nor serial-episode acute care will ever meet the vast need that exists. Only a focus on ongoing recovery support/ management can address effectively the chronic nature of this illness. (White, Kurtz, & Sanders, 2006).

RECOVERY

▶ Recovery is the process of regaining a healthy balance in the lives of persons adversely affected, directly or indirectly, by alcohol and other drug addiction.

Community Recovery Network. Retrieved March 12, 2007 from http://www.facesandvoicesofrecovery.org/resources/miniguide.php

▶ Rapid entry into involvement with a recovery support group during treatment services generates better long-term recovery outcomes than delayed linkage (e.g., following treatment or at a period subsequent to treatment).

Moos, R. & Moos, B. (2005). Paths of entry into Alcoholics Anonymous: Consequences for participation and remission. *Alcoholism: Clinical & Experimental Research. 29*(10), 1858-1868.

▶ The longer the participation in recovery support groups in the three years following primary treatment, the greater the probability of remission at 15+ years following treatment.

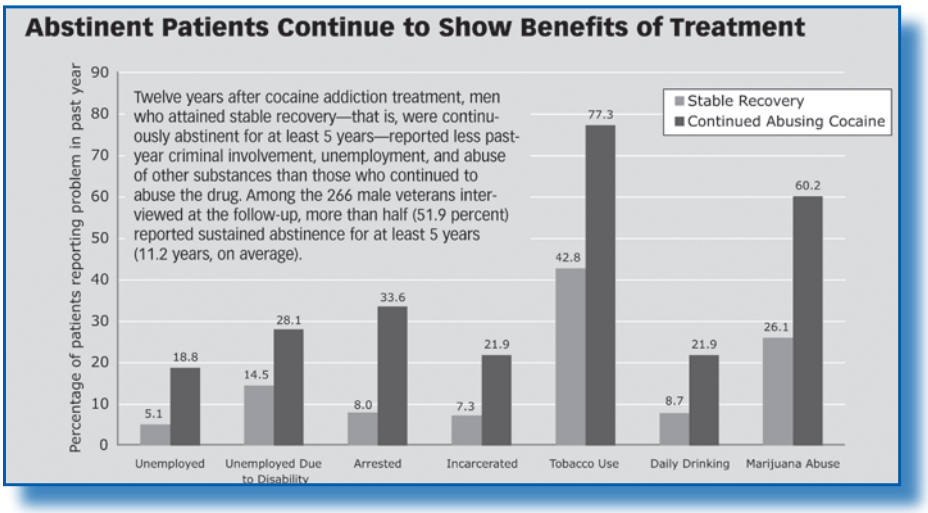
Moos, R. & Moos, B. (2005). Paths of entry into Alcoholics Anonymous: Consequences for participation and remission. *Alcoholism: Clinical & Experimental Research. 29*(10), 1858-1868.

▶ While some individuals disengage from recovery support groups after a period of recovery initiation and sustain stable remission (Kaskutas, et al, 2005), those who sustain recovery support group participation are more likely to be in remission at follow-up than those who disengage.

Moos, R. & Moos, B. (2005). Paths of entry into Alcoholics Anonymous: Consequences for participation and remission. *Alcoholism: Clinical & Experimental Research. 29*(10), 1858-1868.

▶ Even among clients who had already received a substantial 'dose' of treatment, after controlling for other relevant variables, intensive post-treatment self-help dramatically cut the chances of relapsing to weekly cocaine use.

Franey, C. Ashton, M. (2002). The Grand Design lessons from DATOS. *Drug and Alcohol Findings*, 7, 6.



Hser, Y.I. et al. (2006). A 12-year follow-up of a treated cocaine-dependent sample. *Journal of Substance Abuse Treatment 30*(3): 219-226. As published in the NIDA Notes, 21:3 retrieved May 14, 2007 from http://www.nida.nih.gov/PDF/nidanotes/NNvol21N3.pdf

What are the Real Cost Benefits of SUD Treatment?

Over the past twenty years, spending for treatment of substance use disorders in the United States has increased from $11.9 billion in 1997 to approximately $18.7 billion in 2001 (Mark et al., 2001 and 2005. These figures do not take into account the indirect costs accrued to employers, the criminal justice system, and educational systems, not to mention other medical costs to treat the physical manifestations of drug and alcohol use. In 1998, the indirect costs of alcohol-related illness, accidents and other problems were approximately $185 billion (National Institute on Alcohol Abuse and Alcoholism, 2000). Despite the fact that these costs seem extremely high, costs to society would be exponentially greater without the availability of substance use disorder treatment.

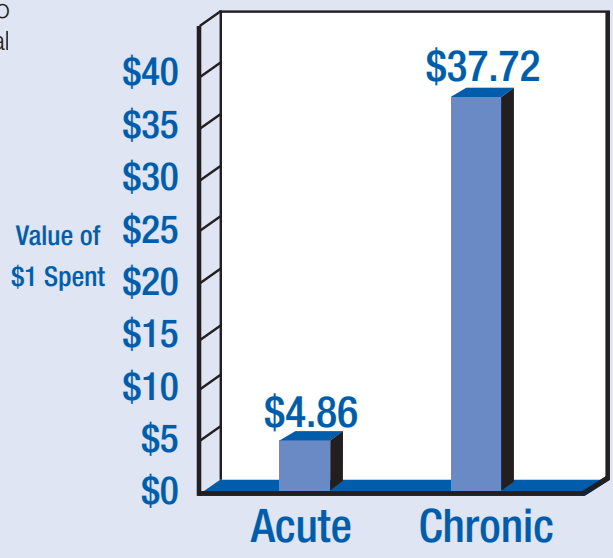
Fortunately, money that pays directly for treatment is being put to good use. Research shows that treatment is cost effective and accrues many benefits to society. One study based on data from California between 2000 and 2001 showed that, on average, for each dollar invested in treatment, society accrues $7 in benefits (Ettner, et al., 2006). Most of these benefits came from reduced costs in crime and increased earnings by individuals who received treatment. Benefits also can come from decreased utilization of medical services. One study that examined costs for recipients of Medicaid benefits showed that among individuals identified as having a substance use disorder, the individuals who received treatment had monthly medical costs that were more than $380 lower per person than individuals who did not receive treatment (Gerson, et al., 2001).

More recent research studying the use of a continuum of care to treat chronic illnesses, such as substance use disorders, suggests that the benefits realized from providing continuing care are even greater when compared to benefits from isolated treatment episodes based on an acute-care model. A recent study shows that the cost-benefit of multiple episodes of treatment over the lifetime of an individual (every $1 spent on treatment results in $37.72 of benefits) exceeds the cost-benefit ratio for a single treatment episode (every $1 spent on treatment results in $4.86 of benefits; Zarkin, Dunlap, Hicks, & Mamo, 2005).

"Drug addiction is a brain disease. Although initial drug use might be voluntary, once addiction develops, this control is markedly disrupted."

Nora D. Volkow, director of the federal government's National Institute on Drug Abuse, *Recovery in Action Rising*. Winter 2007. www.facesandvoicesofrecovery.org

Benefit-Cost Ratio of the First Treatment Episode (Acute Care Model) vs. Lifetime Treatment Episodes (Chronic Care model) for Heroin Users



SOURCE: Cost methodology of COMBINE . Adapted from Zarkin, G.A., Bray, J.W., Mitra, D., Cisler, R.A., & Kivlahan, D.R. (2005 Jul). c. *Journal of Studies on Alcohol. Supplement.,* (15):50-55.

COST-OFFSETS

▶ When adding the savings to healthcare, for every $1 dollar spent in addictions treatment, society benefits by greater than $12.

National Institute on Drug Addiction, U.S. Department of Health and Human Services, National Institutes of Health. (1999). *Principles of Drug Addiction.*

▶ Costs to society when offering a continuum of care beginning with residential or intensive outpatient treatment are between 46% and 65% less than for providing only residential treatment more than two years after treatment initiation.

Koenig, L., Siegel, J.M., Harwood, H., Gilani, J., Chen, Y-J, Leahy, P., & Stephens, R. (2005). Economic Benefits of Substance Abuse treatment: Findings from Cuyahoga County, Ohio. *Journal of Substance Abuse Treatment, 28*(S1), S41-S50.

▶ The average per client economic benefit of addiction treatment on a full or partial continuum of care in Washington State is $8,053 and favors a full continuum over partial continuum.

French, M.T., Salomé, H.J., Krupski, A., McKay, J.R., Donovan, D.M., McLellan, A.T., & Durell, J. (2000). Benefit-Cost Analysis of Residential and Outpatient Addiction Treatment in the State of Washington. *Evaluation Review, 24*(6), 609-634.

▶ The greatest economic savings associated with addiction treatment are in the form of averted criminal activity followed by decreased utilization of health services.

McCollister, K.E. & French, M.T. (2003). The relative contribution of outcome domains in the total economic benefit of addiction interventions: a review of first findings. *Addiction, 98*(12), 1647-1659.

SUSTAINABILITY

▶ Addictions treatment is significantly associated with a 67% reduction in weekly cocaine use, a 65% reduction in weekly heroin use, a 52% decrease in heavy alcohol use, a 61% reduction in illegal activity, and a 46% decrease in suicidal ideation one year post treatment. Moreover, these outcomes are generally stable for the same clients five years post treatment.

Hubbard, R.L. (2003). Overview of 5-Year Follow-Up Outcomes in the Drug Abuse Treatment Outcomes Studies (DATOS). 263-70.

▶ Maintaining therapeutic contact for extended periods of time with individuals with alcohol and other drug disorders appears to promote better long-term outcomes than 'treatment as usual'.

McKay, J.R. (2001). Effectiveness of Continuing Care Interventions for Substance Abusers: Implications for the Study of Long-Term Treatment Effects. *Evaluation Review, 25*(2), 211-232.

▶ TREATMENT GAP: The overwhelming majority of persons who need addictions treatment (over 80%) do not receive treatment.

Knight, J.R., Wechsler, H., Meichun, K., Seibring, M., Weitzman, E.R., & Schuckit, M.A., (2002). Alcohol Abuse and Dependency Among US College Students. Journal of Studies on Alcohol, 63(3), 263-70.

SOURCES:

Ettner, S.L., Huang, D., Evans, E., Ash, D.R., Hardy, M., Jourabchi, M., & Hser, Y-I. (2006). *Health Services Research, 41*(1), 192-213.

Gerson, L.W., Boex, J., Hua, K, Liebelt, R.A., Zumbar, W.R., Bush, D., & Givens, C. (2001). *Journal of Substance Abuse Treatment, 20*(2), 115-120.

Mark, T.L., Coffey, R., King, E.C., Harwood, H.J., McKusick, D., Genuardi, J., Dilonardo, J., & Buck, J.A. (2000). Spending on Mental Health and Substance Abuse Treatment, 1987-1997. *Health Affairs, 19*(4), 108120.

Mark, T.L., Coffey, R.M., Vandivort-Warren, R., Harwood, H.J., King, E.C., the MHSA Spending Estimates Team. (2005). US Spending for Mental Health and Substance Abuse Treatment, 1991-2001. *Health Affairs*, Web Exclusive, w5-133-w5-142.

National Institute on Alcohol Abuse and Alcoholism. (2000). *10th Special Report to the US Congress on Alcohol and Health*. Retrieved on March 13, 2007 from http://pubs.niaaa.nih.gov/publications/10report/intro.pdf

Zarkin, G.A., Dunlap, L.J., Hicks, K.A., & Mamo, D. (2005). Benefits and Costs of Methadone Treatment: Results from a Lifetime Simulation Model. *Health Economics,* 14, 1133-1150.

"Substance abuse is a major national public health problem that creates impaired health, harmful behaviors, and major economic and social burdens... but there are effective medical and public health approaches to the problem."

Adolescent Substance Abuse: A Public Health Priority, Physician Leadership On National Drug Policy, August 2002.

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